Washington State Department of Social & Health Services

Medicaid Reform in Washington State

The search for more flexibility and better management tools to deal with rising costs

Waiver history

During the summer of 2001, the Department of Social and Health Services' Medical Assistance Administration began to develop a Medicare Reform proposal aimed at giving the state more management tools to deal with cost-containment issues during tight economic times.

FIRST WAIVER

An initial draft of the waiver was submitted to the federal Centers for Medicare and Medicaid Services (CMS) in November of 2001. It outlined several areas in which the state needed federal approval to manage programs differently, primarily in the use of small premiums for all Medicaid clients above 100 percent of the Federal Poverty Level, co-payments for non-preventive services, and the flexibility to adopt different benefit designs for optional programs. The waiver also asked permission for the state to use unspent States' Children's Health Insurance Program (SCHIP) funds on other health-care priorities.

SECOND WAIVER

After negotiations with CMS and a series of "town hall" meetings with stakeholders, the original waiver was amended to include five specific changes:

- ▶ Monthly premiums for specified optional groups.
- ▶ Use of unspent SCHIP funds.
- ▶ Co-payments to encourage better utilization of brand name drugs and ER visits.
- ▶ Elimination of adult dental, hearing and vision benefits.
- ▶ Enrollment caps on optional programs that could be invoked when Medicaid exceeded its budget.

THIRD WAIVER

New negotiations with CMS persuaded legislators that the premiums would be favorably reviewed, and the Legislature included them in its 2003-05 budget. The waiver was redrafted to focus only on the new monthly premiums. It was resubmitted to CMS in July 2003.

WHY REFORM? Washington State has been a national leader in providing health care to its children, vulnerable adults, and the working poor for decades. In a time of lower health care costs and more state funding, the state was able to expand coverage. But after the new millennium arrived, health costs resumed their significant rates of increase, and the demand for coverage and services continued to grow. The Department of Social and Health Services (DSHS) provides medical assistance to more than 900,000 Washington residents each month, and the weight of those costs has increased in recent years at the rate of a half billion dollars a year. Although Medicaid today consumes more than 40 percent of the total DSHS budget, low reimbursement levels are leading some providers to limit Medicaid caseload.

The Background

In the fall of 2001, Medical Assistance Administration (MAA) unveiled its first draft of a 1115 Demonstration Waiver aimed at giving the state new flexibility in dealing with its health care expenditures. But in subsequent meetings with stakeholders, clients, legislators and the federal Centers for Medicare and Medicaid Services (CMS), it became clear that the initial proposal needed revision. Critics who felt the waiver proposal went too far and those who felt it did not go far enough agreed on one thing: MAA needed to be much more specific about the circumstances in which it would use its requested flexibility. So in May and June, MAA went back to the drawing board, holding a series of Town Meetings around the state to solicit feedback on the waiver. The meetings also helped clarify access issues around a proposed co-payment on non-emergency visits to hospital emergency rooms. A second version of the waiver was submitted to the federal Centers for Medicare and Medicaid Services (CMS) in August 2002, but negotiations between the state and CMS remained inconclusive as 2003 began.

Federal Poverty Levels

Family size	Annual income
1	$8,980
2	$12,120
3	$15,260
4	$18,400

The Third Amended Waiver

Meanwhile, the state's budget crisis deepened, with more than a $2.5 billion shortfall in revenues. The Legislature's budget for the new biennium cut services and tightened belts across state government, including Medicaid. It also adopted a new version of the monthly premiums proposed in the Medicaid Reform Waiver. As a result, the waiver application was rewritten again, this time to outline the changes necessary under the new legislative budget. The changes were sent to CMS in late July 2003.

Washington: The Bellwether State

Children

The Legislature authorized three major expansions of health coverage for low-income children during the past decade. As a result, enrollment in children's Medicaid programs increased 12.5 percent per year between 1996 and 2001. It is projected to increase another 7.5 percent during the next two years.

Pregnant Women

The Medicaid-financed First Steps program was implemented in 1989 to provide health-care coverage to pregnant women and infants in households up to 185 percent of the federal poverty level. Currently, Washington's Medicaid program covers two in every five births in the state. In addition, Washington State Medicaid funds are targeting a reduction in unintended pregnancies by offering free family planning and education services to low-income residents.

Seniors

Many low-income seniors have sought Medicaid coverage to offset the growth in health-care costs, especially prescription drugs and medical equipment. (Neither of these is covered by Medicare.) Monthly per capita expenditures for prescription drugs for low-income seniors jumped from $118 in fiscal 1996 to $172 in fiscal 2001 – an annual increase of about 9 percent. As a result, DSHS caseloads for the elderly increased 12 percent a year between 1996 and 2001. The trend is expected to continue in the current biennium.

NOTE: The waiver proposal for Washington does not affect Medicaid's Long-Term Care benefits, which rank among its highest costs.

Questions About the Waiver?

Check out the web page:
http://maa.dshs.wa.gov/medwaiver

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Persons with disabilities or special needs may call **360-902-7604** or e-mail stevejhs2@dshs.wa.gov and request a hard copy.

Features of the newly-amended waiver

Eligibility groups subject to premiums

MAA's Section 1115 demonstration waiver application originally sought a waiver of 1902(a)(14) and 1916(a)(1) in order to allow Washington State to impose premiums on Medicaid Categorically Needy (CN) optional children, i.e., broad flexibility to adopt premiums for all mandatory and optional eligibility groups for persons in families with incomes above 100% of FPL. MAA also sought flexibility under Section 1925(a)(25), to allow for these same parameters to apply to families receiving Medicaid Transitional Medical Assistance (TMA). Total cost-sharing (co-payments and premiums) would comport with SCHIP and HIFA requirements and not exceed 5% of family income. While the actual groups subject to premiums and premium amounts would have been determined by the state Legislature, the waiver exempted American Indians (AI) and Native Alaskans (NA) from all cost-sharing, including premiums. The next version of the waiver was submitted after feedback from both CMS and stakeholders who wanted a more detailed proposal. Based on discussions with CMS, premiums in the second waiver proposal would have been restricted to optional populations. MAA considered whether to impose premiums on all CN optional populations, including CN Aged, CN Blind/Disabled, CN optional children, CN women with breast and cervical cancer, CN healthcare for workers with disabilities, MN Aged, MN Blind/Disabled and MN Other, but after further internal deliberations and stakeholder comments, the revised application was submitted in August 2002, seeking necessary waivers to impose premiums on CN optional children, MN Aged, MN Blind/Disabled and MN Other whose family incomes exceeded 100% of FPL. After further review and CMS negotiations, MAA's third waiver submission limits premiums to only CN optional children with incomes above 100% of FPL. (American Indians and Native Alaskan clients are again exempt from these requirements.) CN optional children are defined as non-grant children (e.g., infants up to age 1 in households between 185% and 200% FPL; children age 1 through 5 in households between 133% and 200% FPL; and children age 6 through 18 in households between 100% and 200% FPL. This population does not include SSI-related children regardless of income. However, so-called "children with special health care needs" who are CN optional would be subject to premiums if they otherwise meet the age and income levels described above.

Structure of premiums

Premium amounts were not specified in the original waiver proposal. The August 2002 revised waiver application set specific premium amounts at: $10 per-child per-month for families with incomes between 100% and 150% of the federal poverty level (FPL); $15 per-child per-month for families with incomes between 150% and 200% of FPL; and $20 per-child per-month for SCHIP families with incomes above 200% of FPL. These premiums would have been subject to a three-person household limit. The Legislature set slightly higher levels of premiums in its budget. Those are:

▶ $15 per-child per-month for families with incomes between 100% and 150% of the federal poverty level (FPL)
▶ $20 per-child per-month for families with incomes between 150% and 200% of FPL.
▶ $25 per-child per-month for families with incomes above 200% of FPL.
▶ These premiums are subject to a three-person household limit. They do not exceed 3.0% of families' gross income.

Sponsors

All three versions of the waiver allow for premium sponsorship, similar to the system in place for the state's Basic Health program. As sponsors, private, nonprofit or public entities can choose to pay the premium obligation for Medicaid or SCHIP children. In our August 2002 application, we defined sponsors to include "employers, providers and non-providers."